



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER, GOVERNOR  
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. - Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-8626  
FAX: (208) 364-1888  
E-mail: fsb@idhw.state.id.us

September 30, 2008

RECEIVED

OCT 16 2008

Teresa Carpenter  
Preferred Community Homes Courtyard  
615 Second Avenue West  
Wendell, Idaho 83355

FACILITY STANDARDS

RE: Preferred Community Homes Courtyard, Provider #13G057

Dear Ms. Carpenter:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes Courtyard, which was conducted on September 25, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important** that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

Teresa Carpenter  
September 30, 2008  
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 13, 2008**, and keep a copy for your records.

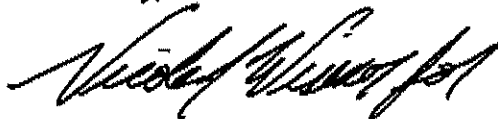
You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by October 13, 2008. If a request for informal dispute resolution is received after October 13, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey.</p> <p>The surveyors conducting the survey were: Jim Troutfetter, QMRP, Team Leader Michael Case, LSW, QMRP</p> <p>Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder BMP - Behavior Management Program GERD - Gastroesophageal Reflux Disease HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse PICA - Eating Non-Food Items QMRP - Qualified Mental Retardation Professional RSC - Residential Service Coordinator SIB - Self Injurious Behavior TD - Tardive Dyskinesia WIC - Written Informed Consent</p>	W 000	<p><b>W 000 INITIAL COMMENTS</b></p> <p>"Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated September 25, 2008. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard - Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."</p>		
W 120	<p><b>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</b></p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure outside services met the needs of 6 of 6 individuals (Individuals #1 - #6) who attended public school. This resulted in a lack of coordination between the school and the facility regarding behavioral issues. The findings include:</p>	W 120	<p><b>W 120 483.410(d)(3) Services provided with outside Sources</b></p> <p>For clients #1-#6, the staff at the public school will be trained and in-serviced on all BMP's. The school will be observed on all programs and interactions with clients #1 thru #6. Training will be done on a Quarterly basis and documentation will be recorded of each training and in-service. This will be done for all clients residing at Courtyard to ensure the deficient will not recur.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jeresa Carpenter

Admin

10/13/08

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 1</p> <p>1. During the entrance conference on 9/22/08 at 9:30 a.m., the Administrator stated all six individuals residing at the facility attend public school.</p> <p>An observation was conducted at the public school on 9/23/08 from 8:25 - 9:15 a.m., at which time the following concerns were noted:</p> <p>a. Individual #5 was observed to bang her head against a desk. However, the staff working with Individual #5 did not document the head banging.</p> <p>When asked, the Special Education Teacher, who was present during the observation, stated the school was not sure how to run Individual #5's BMP from the facility.</p> <p>b. Individual #3 was noted to be sitting in a single student desk that was accessible from one side. The staff working with Individual #3 turned the desk so the opening was against a brick wall and the back of the seat was against a wooden cabinet. The staff then sat to the side of Individual #3's desk and placed her feet against the legs of the desk, holding it against the wall.</p> <p>When asked, the Special Education Teacher, who was present during the observation, stated Individual #3's desk was placed against the wall to prevent him from continually standing up, but Individual #3 could indicate he wanted to get up by pushing the desk away from the wall. When asked how Individual #3 could push the desk away from the wall with the staff's feet against the legs, the Special Education Teacher stated Individual #3 could not. When asked if the technique of holding the desk against the wall was incorporated into a plan, the Special</p>	W 120	To be completed by the QMRP, RSC, and the Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 2</p> <p>Education Teacher stated it was not.</p> <p>c. Individual #6's BMP, revised 7/08, included the use of a gait belt during moving restraints to ensure his safety. When asked about the use of the gait belt, the Special Education Teacher, who was present during the observation, stated Individual #6 did not like the gait belt, so staff could just show it to Individual #6 to get him to comply.</p> <p>d. When asked if the school sent behavioral data for individuals #1 - #6 to the facility, the Special Education Teacher, who was present during the observation, stated he had been unaware he needed to send behavioral data home, but found out the previous week he needed to do so. Additionally, the Special Education Teacher stated the school had received individuals' BMPs from the facility but had not been inserviced on the implementation of the BMPs. When asked if staff from the facility came to the school to observe, a second Special Education Teacher, who was present during the observation, stated the facility's LPN was the only staff that had come to the school.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated he had gone to the school but did not maintain documentation of the visits, or documentation of inservicing individuals' BMPs. When asked if the school should be completing neuro-checks when Individual #5 banged her head, the QMRP stated they should. When asked about the school turning Individual #3's desk to the wall to prevent him from getting up, the QMRP stated he was not aware of this practice. When asked about the manner in which the school used Individual #6's</p>	W 120			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	Continued From page 3 gait belt, the QMRP stated it was not appropriate and he was not aware of this practice.  Additionally, the Administrator, who was present during the interview, stated she had clarified with the school the previous week regarding sending behavioral data to the facility, but data was not received prior to that time.  The facility failed to ensure the school services for Individuals #1 - #6 were sufficiently monitored and coordinated.	W 120			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 2 of 3 individuals (Individual #1 and #3) whose written informed consents were reviewed. This resulted in a lack of information being provided to individuals' guardians regarding restrictive interventions. The findings include:  1. Individual #1's 7/14/08 IPP stated he was a 10 year old male whose diagnoses included profound mental retardation, ADHD, and autism. His Physician's Order, dated 8/08, stated he	W 124	<b>W 124 483.420(a)(2) Protection of clients rights</b>  Client #1 and #3 consents will be re-done, to include all information including but not limited to side effects, alternative treatment, risk of treatment, the right to refuse treatment and etc. This will be done for all clients residing at Courtyard to ensure the deficient will not recur. Consents will be included on a quarterly checklist to ensure that all information is contained in the consents.  To be completed by the QMRP, and the Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 124	<p>Continued From page 4</p> <p>received Abilify (an antipsychotic drug) 30 mg per day and Concerta (a stimulant drug) 36 mg per day.</p> <p>Individual #1's consents were reviewed and included a Resident Medication Change Form, dated 3/24/08, for Concerta that included verbal consent from Individual #1's guardian and the HRC. However, the form did not include information regarding the drug, (e.g., side effects, alternative treatments, risk of treatment, right to refuse treatment, etc.).</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated additional information was not present and the WIC had not been developed for Individual #1's Concerta.</p> <p>The facility failed to ensure Individual #1's guardian was provided sufficient written information regarding the use of Concerta.</p> <p>2. Individual #3's IPP, dated 1/3/08, documented a 15 year old male diagnosed with profound mental retardation, autistic disorder, and a history of a seizure disorder. Individual #3's Supplemental or Treatment Notes, dated 4/22/08, documented he received Valium for a dental appointment.</p> <p>Individual #3's Dental/Medical Visit Medication Reduction Plan for Valium (an anxiolytic drug), dated 3/3/08, included signatures from the guardian, dated 3/3/08, and the HRC, dated 6/12/08. However, the form did not include information regarding the drug, (e.g. side effects, alternative treatments, risk of treatment, right to refuse treatment, etc.).</p>	W 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 124	Continued From page 5 When asked during an interview on 9/24/08 at 5:15 p.m. the QMRP stated there was no additional information regarding the use of Valium for Individual #3.	W 124			
W 149	The facility failed to ensure Individual #3's guardian was provided sufficient written information regarding the use of Valium. 483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures and staff interview, it was determined the facility failed to adequately develop policies necessary to protect individuals from abuse, neglect and/or mistreatment by the administrator for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 5/30/08, did not include procedures to be followed if the Administrator was the person accused of abuse. Therefore, the policy did not identify who was responsible to perform the duties assigned to the Administrator as the result of an abuse, neglect, or mistreatment allegation. Those duties included, but were not limited to, immediate notification, immediate action to protect from further abuse, ability to suspend staff, and reporting to appropriate agencies.	W 149	W 149 483.420(d)(1) Staff treatment of clients.  The facility's Abuse, Neglect Mistreatment and injuries of an Unknown Source policy will be revised to include the policy will instruct all employee's what to do if the Administrator is the one accused of Abuse. Policies will be read and revised as needed to ensure the deficient will not recur.  To be completed by the Regional Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	Continued From page 6	W 149			
W 159	<p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the Administrator stated the abuse policy did not include procedures to be followed if the Administrator was the person accused of abuse.</p> <p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. That failure resulted in individuals not receiving the services and training required to meet their needs. The findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to W120 as it relates to the QMRP's failure to ensure individuals' outside services were sufficiently coordinated.</li> <li>2. Refer to W124 as it relates to the QMRP's failure to ensure individuals' consents were informed.</li> <li>3. Refer to W214 as it relates to the QMRP's failure to ensure individuals' behavioral assessments contained comprehensive information.</li> <li>4. Refer to W227 as it relates to the QMRP's failure to ensure an individual's plan included</li> </ol>	W 159	<p><b>W 159 483.430 (a) Qualified Mental retardation Professional</b></p> <p>In order to ensure that the QMRP provides sufficient monitoring and coordination of the status of the Courtyard clients, the plan of correction for the following federal citations listed under W 159 will serve as the plan of action to ensure individuals residing at Courtyard will receive services and required training to meet their development and behavioral needs.</p> <p>Please refer to W120, W124, W214 W227, W252, W289, and W312 for specific information relating to those deficiencies.</p> <p>To be completed by the QMRP, Behavioral specialist, and Administrator by 11/25/08.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	Continued From page 7 specific objectives necessary to meet his needs.  5. Refer to W252 as it relates to the QMRP's failure to ensure behavioral data was collected in a form relevant to an individual's needs.  6. Refer to W289 as it relates to the QMRP's failure to ensure systematic interventions for maladaptive behaviors were incorporated into a plan.  7. Refer to W312 as it relates to the QMRP's failure to ensure drugs used to control maladaptive behaviors were incorporated into a plan.	W 159			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.  This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 5 of 6 individuals (Individuals #1, #2, #4, #5, and #6) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:  1. Individual #1's 7/14/08 IPP stated he was a 10 year old male whose diagnoses included profound mental retardation, ADHD, and autism.  Individual #1's Ongoing Mental Status Examination notes were reviewed and	W 214	W 214 483.440(c)(3)(iii) Individual program plans  Individuals #1,2,4,5,and 6 Behavioral assessments will re-assessed and re-done to include all information to which is needed to base program interventions on. The behavioral assessments and the IPP's will be cross referenced to ensure that no pertinent information is missed and that all comprehensive information is included. This will be done every time that there is a revision made to an assessment and yearly at the IPP meeting to ensure this deficient will not recur. Quarterly checks will be conducted, monitoring will be done to make sure the IPP's, behavioral assessments all match with no missing information.  This will be done by the QMRP, Behavioral Specialist, and the Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	<p>Continued From page 8</p> <p>documented the following behaviors:</p> <ul style="list-style-type: none"> <li>- 11/26/07: The notes documented Individual #1 was restrained for hitting staff.</li> <li>- 1/7/08: The note documented "Autism - non-compliance."</li> <li>- 3/3/08: The note documented Individual #1 exhibited hair pulling.</li> <li>- 7/14/08: The note documented Individual #1 exhibited biting self.</li> <li>- 7/28/08: The note documented Individual #1 exhibited "some biting."</li> <li>- 8/18/08: The note documented Individual #1 had been pinching people, pulling hair, biting objects, biting others, and biting himself.</li> </ul> <p>However, Individual #1's Behavioral Assessment, revised 7/3/08, stated Individual #1's maladaptive behaviors included uncooperative behavior, defined as crouching down on the floor, and disruptive behavior, defined as screaming. The assessment did not include information regarding hitting, non compliance, hair pulling, biting self, biting others, biting objects, or pinching others.</p> <p>Additionally, Individual #1's Behavioral Assessment included a diagnosis of ADHD but did not include his diagnosis of autism, and did not include information related to the impact autism may have on his maladaptive behaviors.</p> <p>Without comprehensive assessment of Individual #1's maladaptive behaviors, the facility would not be able to appropriately address all behavioral needs.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated the behaviors identified by the psychiatrist were not being</p>	W 214			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	<p>Continued From page 9 tracked and had not been assessed.</p> <p>The facility failed to ensure Individual #1's behavior assessment included an assessment of all maladaptive behaviors.</p> <p>2. Individual #4's Behavioral Assessment, revised 8/20/08, stated he was a 17 year old male whose diagnoses included profound mental retardation, autism, and GERD with rumination.</p> <p>During an observation on 9/23/08 from 6:00 - 6:55 a.m., the following maladaptive behaviors were noted:</p> <ul style="list-style-type: none"> <li>- 6:25 a.m., Individual #4 repeatedly slapped the couch on either side of him with a flat hand. The staff working with him did not respond.</li> <li>- 6:40 a.m., Individual #4 went into his bedroom and repeatedly hit his dresser with a flat hand. The staff working with him said "soft touch."</li> <li>- 6:45 a.m., Individual #4 hit the television in his bedroom with a flat hand, hit the dresser with a flat hand, and made loud vocalizations. The staff working with him said "soft touches."</li> <li>- 6:50 a.m., Individual #4 walked down the hallway and repeatedly slapped the wall with a flat hand and made loud vocalizations. The staff working with him said "soft touch" and used hand over hand assistance to touch Individual #4's hand to the wall. Once in the living room, Individual #4 sat on the couch and began repeatedly slapping the couch on either side of him. The staff sitting next to him mimicked the behavior. The staff sitting with Individual #4 stated "He's having a bad day."</li> </ul> <p>During an observation at Individual #4's school, on 9/23/08 from 8:30 - 9:15 a.m., Individual #4 was observed to repeatedly slap a tall metal file</p>	W 214			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	<p>Continued From page 10</p> <p>cabinet beside his desk and make loud vocalizations. The staff working with Individual #4 rubbed his back and spoke quietly with him. The staff had Individual #4 go to an over-stuffed rocking chair where he sat and rocked for no less than 20 minutes.</p> <p>Individual #4's Behavioral Assessment, revised 8/20/08, stated his maladaptive behaviors included socially offensive behavior defined as burping and spitting. The Behavioral Assessment did not include information regarding hitting of objects or loud vocalizations when upset.</p> <p>Without comprehensive assessment of Individual #4's maladaptive behavior, the facility would not be able to appropriately address all behavioral needs.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated Individual #4's Behavioral Assessment did not include information regarding hitting objects and loud vocalizations, and stated the behavior needed to be reassessed.</p> <p>The facility failed to ensure Individual #4's Behavioral Assessment addressed all maladaptive behaviors.</p> <p>3. During observations on 9/22/08 from 2:50 - 3:40 p.m. and 4:40 - 5:30 p.m., and on 9/23/08 from 6:00 - 6:55 a.m., all six individuals residing in the facility were noted to have one-to-one staffing. When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the Administrator stated Individuals #2, #5, and #6 required one-to-one staffing due to behavioral issues. The Administrator stated the other three individuals</p>	W 214			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/25/2008
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - COURTYARD

615 SECOND AVENUE WEST  
WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	<p>Continued From page 11</p> <p>did not require one-to-one staffing, but were provided one-to-one staffing for more individualized programming.</p> <p>a. Individual #2's Behavioral Assessment, revised 7/3/08, stated his maladaptive behaviors included hitting, biting self and others, pinching, scratching, kicking, head butting others, head banging, inappropriate touching, inappropriate sexual language, spitting, swearing, threats of suicide, yelling/screaming, and refusals.</p> <p>Individual #2's Behavioral Assessment included interventions to address his maladaptive behaviors that included verbal redirection, body blocking and one and two person restraint, but did not include the use of one-to-one staffing and the impact this would have on Individual #2.</p> <p>b. Individual #5's Behavioral Assessment, dated 3/20/08, stated her maladaptive behaviors included head banging, hitting herself in the face, kicking herself, head butting others, hitting, pinching, kicking, scratching, biting others, and crying.</p> <p>Individual #5's Behavioral Assessment included interventions to address her maladaptive behaviors that included verbal redirection, blocking and redirecting, physical assistance to stand, and a one and two person moving restraint, but did not include the use of one-to-one staffing and the impact this would have on Individual #5.</p> <p>c. Individual #6's Behavioral Assessment, revised 7/26/08, stated his maladaptive behaviors included non-compliance, elopement, hitting self and others, biting self and others, scratching,</p>	W 214		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	Continued From page 12 kicking, head butting others, and head banging.  Individual #6's Behavioral Assessment included interventions to address his maladaptive behaviors that included physically blocking and redirecting, one and two person moving restraint, a helmet to protect his head, and a gait belt to assist with moving restraint, but did not include the use of one-to-one staffing and the impact this would have on Individual #6.  When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated one-to-one staffing needs and their impact had not been included in individuals' Behavioral Assessments.  The facility failed to ensure Individual #2, Individual #4, and Individual #6's Behavioral Assessments included the individuals' need for one-to-one staffing.	W 214			
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the IPP included objectives to meet the needs for 1 of 3 individuals (Individual #3) whose IPPs were reviewed. This resulted in a lack of program plans designed to address the needs of an individual in an area most likely to impact his life. The findings include:	W 227	<b>W 227 483.440(c)(4) Individual program plan</b>  Client #3 Behavioral Assessment will be re-evaluated to make sure that all information is correct and if not correct will be removed. The IPP will be matched to the behavioral assessment to ensure that all information matches.  This will be done by the QMRP, Behavioral Specialist, and the Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 227	Continued From page 13 1. Individual #3's IPP, dated 1/3/08, documented a 15 year old male diagnosed with profound mental retardation, autistic disorder, and a history of a seizure disorder.  The "Description of Behavior" section of Individual #3's Behavioral Assessment, dated 7/10/08, documented PICA as one of his current maladaptive behaviors. However, Individual #3's IPP contained no objective to address PICA.  When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated Individual #3 did not have a program for PICA.  The facility failed to ensure Individual #3's IPP contained specific objectives to meet his behavioral needs.	W 227			
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 1 of 3 individuals (Individual #1) reviewed. By not ensuring appropriate data collection, the facility could not make objective decisions regarding an individual's success or lack of success. The findings include:  1. Individual #1's 7/14/08 IPP stated he was a 10	W 237	W 237 483.440(c)(5)(iv) Individual program plan  Client #1 data collection will be revised to a daily collection amount of more than 15 minute time frames to ensure that the facility can get a true reflection of the maladaptive behavior that is occurring. The BMP will then be re-assessed to include the appropriate information. Data collection will be looked at, and if appropriate will be revised for all clients residing at Courtyard to ensure the deficient will not recur.  To be completed by the QMRP, Behavioral Specialist, and Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 237	<p>Continued From page 14</p> <p>year old male whose diagnoses included profound mental retardation, ADHD, and autism. His Physician's Order, dated 08/08, stated he received Abilify (an antipsychotic drug) 30 mg a day and Concerta (a stimulant drug) 36 mg a day.</p> <p>Individual #1's BMP, revised 7/15/08, stated he exhibited disruptive behavior, defined as screaming, and uncooperative behavior, defined as "crouching down to the floor." The BMP included an objective which stated Individual #1 "will decrease uncooperative behavior (crouching down to the floor) to 2 incidents per 15 minute observation (x1 per AM shift, x1 per PM shift every 3rd day) average per month for 3 consecutive months." Under the "Data" section, the plan stated "To be collected once per AM shift and once per PM shift every third day during a 15 minute observation."</p> <p>Additionally, Individual #1's Medication Reduction Plan, dated 6/30/08, stated in order to reduce both Abilify and Concerta Individual #1 would need to meet criteria for uncooperative behavior.</p> <p>By only recording data during a 15 minute period, once on the a.m. and once on the p.m. shift every third day, the data would not demonstrate a true reflection of Individual #1's maladaptive behavior.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated he completed 15 minute observations every three days and attempted to complete the observations at different times during different tasks.</p> <p>The facility failed to ensure data for Individual #1's maladaptive behavior was collected in such a way as to provide accurate and comprehensive</p>	W 237			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 237  W 289	<p>Continued From page 15</p> <p>Information relative to decision making.</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into program plans for 3 of 6 individuals (Individuals #2, #5, and #6) whose behavior plans were reviewed. This resulted in interventions being used which were not included in individuals' IPPs. The findings include:</p> <p>1. During observations on 9/22/08 from 2:50 - 3:40 p.m. and 4:40 - 5:30 p.m., and on 9/23/08 from 6:00 - 6:55 a.m., all six individuals residing in the facility were noted to have one-to-one staffing. When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the Administrator stated Individuals #2, #5, and #6 required one-to-one staffing due to behavioral issues. The Administrator stated the other three individuals did not require one-to-one staffing, but were provided one-to-one staffing for more individualized programming.</p> <p>The facility's BMPs were reviewed and showed the following:</p>	W 237  W 289	<p><b>W 289 483.450(b)(4)</b> <b>MGMT OF INAPPROPRIATE</b> <b>CLIENT BEHAVIOR</b></p> <p>All interventions used to manage inappropriate client behavior will be incorporated into the IPP. The behavioral assessment will be revised and the BMP revised and incorporated into the IPP. this will be done for all clients residing at Courtyard to ensure this deficient will not recur. For clients #2,5, and 6 the IPP's and BMP's will be redone to include all information regarding one on one staffing. This will also be done for all client's residing at Courtyard that are requiring one on one staffing. Quarterly checks will be conducted and monitoring will be done to make sure the IPP's. Behavioral assessments, and BMP's all match with no missing information.</p> <p>This will be done by the QMRP, Behavioral Specialist, and the Administrator by 11/25/08.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 289	<p>Continued From page 16</p> <p>a. Individual #2's BMP, revised 4/9/08, included interventions for aggression, self abuse, uncooperative behavior, disruptive behavior, and suicide threats. However, the plan did not include information related to Individual #2's one-to-one staff (i.e., to be used only during waking hours, to be in the same room, to be in line of sight, to be within arms length, etc.).</p> <p>b. Individual #5's BMP, dated 1/7/08, included interventions for aggression and self abuse. However, the plan did not include information related to Individual #5's one-to-one staff (i.e., to be used only during waking hours, to be in the same room, to be in line of sight, to be within arms length, etc.).</p> <p>c. Individual #6's BMP, revised 7/08, included interventions for aggression and self abuse. However the plan did not include information related to Individual #6's one-to-one staff (i.e., to be used only during waking hours, to be in the same room, to be in line of sight, to be within arms length, etc.).</p> <p>During an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated instructions regarding one-to-one staffing had not been included in individuals' BMPs but should have been.</p> <p>The facility failed to ensure that the use of one-to-one staffing was included in plans for Individuals #2, #5 and #6.</p>	W 289			
W 312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual</p>	W 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 312	<p>Continued From page 17</p> <p>elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's 7/14/08 IPP stated he was a 10 year old male whose diagnoses included profound mental retardation, ADHD, and autism. His Physician's Order, dated 8/08, stated he received Abilify (an antipsychotic drug) 30 mg a day and Concerta (a stimulant drug) 36 mg a day.</p> <p>Individual #1's Psychotropic Medication Reduction Plan, dated 6/30/08, stated Abilify and Concerta were prescribed for ADHD exhibited by "Uncooperative behavior." The "Reduction Criteria" section of the form stated Individual #1 "will have fewer than 3 incidents of uncooperative behavior (squatting down) on average, per 15 minutes observation, per month for 3cm [consecutive months]."</p> <p>However, Individual #1's Behavioral Assessment, revised 7/3/08, stated "Abilify and Concerta, for ADHD, with the purpose of increasing [individual</p>	W 312	<p><b>W 312 483.450(e)(2) DRUG USAGE</b></p> <p>#1 medication reduction plan will have clear and comprehensive information that is related to the medications, so that the facility can develop a clear plan as to how the drugs would change based upon #1's behavior. All clients that use drugs to control inappropriate behavior will only be used as an integral part of the client's IPP that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. All med reduction plans will be re-assessed and revised if needed for all clients residing at Courtyard to ensure that this deficient will not recur. this will be done on a quarterly checklist.</p> <p>To be completed by the QMRP, Behavioral Specialist, and the Administrator by 11/25/08.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
W 312	<p>Continued From page 18</p> <p>#1's] attention to tasks." The "Psychotropic Medications Reduction Objective" section of the Behavioral Assessment stated Individual #1's reduction criteria was attending to a household task for 5 seconds with three verbal prompts or less for 75% of all trials for six consecutive months. Additionally, under the "Impact of Daily Living" section the Behavioral Assessment stated Individual #1's "crouching down to the floor throughout the day to avoid a task, has little impact as he is very easily directed to stand."</p> <p>The purpose and reduction criteria for Abilify and Concerta listed on Individual #1's Medication Reduction Plan did not match the purpose and criteria listed in his Behavioral Assessment. Additionally, the maladaptive behavior tied to both Abilify and Concerta in Individual #1's Medication Reduction Plan was identified in his Behavioral Assessment as having "little impact" on his daily life.</p> <p>Further, Individual #1's Ongoing Mental Status Examination notes were reviewed and documented the following:</p> <ul style="list-style-type: none"> <li>- 1/7/08: "Abilify...Autism - non compliance [sic]."</li> <li>- 3/3/08: "May need to add med for ADHD issues."</li> <li>- 3/10/08: "ADHD symptoms will look at meds [sic] if having problem..."</li> </ul> <p>Individual #1's record included a Resident Medication Change Form, dated 3/24/08, that stated Concerta was to be started.</p> <p>Without clear and comprehensive information related to the purpose of Individual #1's Abilify and Concerta it would not be possible for the facility to develop a clear plan as to how the drugs</p>	W 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 312	Continued From page 19 would change based upon Individual #1's behavior.  When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP and Administrator both stated Individual #1's Medication Reduction Plan needed to be revised.  The facility failed to ensure Individual #1's plan included clear information regarding the purpose of Abilify and Concerta, and how the drugs use would change in relation to progress or regression.	W 312			
W 315	<b>483.450(e)(4)(i) DRUG USAGE</b>  Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the drugs used for control of inappropriate behavior were monitored closely for adverse side effects for 4 of 4 individuals (Individuals #1, #2, #3, and #5) who received behavior modifying drugs. This resulted in individuals receiving behavior modifying drugs without appropriate monitoring to determine if the medication was producing the desired response and adjusted if adverse effects were noted. The findings include:  1. Individuals' psychotropic drug use was reviewed and showed the following concerns:  a. Individual #1's Physician's Order, dated 8/08, stated he received Abilify (an antipsychotic drug)	W 315	<b>W 315 483.450(e)(4)(i) DRUG USAGE</b>  Clients #1, 2, 3, and 6 will all have TD ratings done. All clients residing at Courtyard will be monitored closely for desired response and adverse consequences by the facility staff. Possible side affect of all medications will be monitored and assessments completed on all clients residing at Courtyard to ensure this deficient will not recur. This will done by a quarterly checklist.  To be completed by the QMRP, Behavioral Specialist, and the Administrator by 11/25/08.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/25/2008
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 315	<p>Continued From page 20</p> <p>and Concerta (a stimulant drug). The 2008 edition of the Nursing Drug Handbook lists tardive dyskinesia (a disorder involving involuntary muscle movement) as a possible side effect of both drugs. However, Individual #1's record did not include documentation TD ratings had been completed.</p> <p>b. Individual #2's Physician's Order, dated 8/08, stated he received Concerta (a stimulant drug), Seroquel (an antipsychotic drug), and Geodon (an antipsychotic drug). The 2008 edition of the Nursing Drug Handbook lists tardive dyskinesia as a possible side effect of all three drugs. However, Individual #2's record did not include documentation TD ratings had been completed.</p> <p>c. Individual #3's Physician's Order, dated 8/08, stated he received Risperdal (an antipsychotic drug), Zyprexa (an antipsychotic drug), and Seroquel (an antipsychotic drug). The 2008 edition of the Nursing Drug Handbook lists tardive dyskinesia as a possible side effect of all three drugs. However, Individual #3's record did not include documentation TD ratings had been completed.</p> <p>d. Individual #6's Physician's Order, dated 8/08, stated he received Risperdal (an antipsychotic drug) and Seroquel (an antipsychotic drug). The 2008 edition of the Nursing Drug Handbook lists tardive dyskinesia as a possible side effect of both drugs. However, Individual #8's record did not include documentation TD ratings had been completed.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the Administrator stated TD ratings had not been completed on any individual.</p>	W 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 315	Continued From page 21	W 315			
W 322	<p>The facility failed to ensure Individuals #1, #2, #3, and #6 received TD ratings.</p> <p><b>483.460(a)(3) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure preventative and general care was provided to 5 of 5 individuals (Individuals #1, #2, #3, #5 and #6) whose medical needs related to maladaptive behavior were reviewed. This failure resulted in a lack of sufficient information being provided to medical personnel. The findings include:</p> <p>1. Individual #5's BMP, dated 1/7/08, included an objective for SIB, defined as head banging, biting, hitting and kicking herself. The plan stated "a Neuro-check Must [sic] be done" each time Individual #5 hit her head.</p> <p>During an observation at the public school, on 9/23/08 from 8:25 - 9:15 a.m., Individual #5 was observed to bang her head against the desk. The staff working with Individual #5 did not document the incident. The Special Education Teacher, who was present during the observation, stated the school staff did not know how to run Individual #5's BMP from the facility.</p> <p>When asked during an interview on 9/24/08 from 3:55 - 5:10 p.m., the QMRP stated neurological checks for SIB were not being completed by the school. The QMRP stated the school was</p>	W 322	<p><b>W 322 483.460(a)(3) PHYSICIAN SERVICES</b></p> <p>FOR CLIENTS #1, 2, 3, 5, AND 6 the school staff will all be trained on preventive and general medical care. They will be trained on all BMP's Neuro checks and SIB's. The school will be trained on every client residing at Courtyard to ensure this deficient will not recur. This will be done quarterly and documented.</p> <p>To be completed by the QMRP, And Administrator by 11/25/08. Also refer to W315.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	Continued From page 22 provided with the neuro-check forms on 9/24/08.	W 322			
W 382	<p>The facility failed to provide recommended evaluations.</p> <p>2. Refer to W315 as it relates to the facility's failure to ensure individuals receiving psychotropic drugs were provided TD ratings.</p> <p><b>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</b></p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. During an observations on 9/22/08 from 4:40 - 5:30 p.m. and on 9/23/08 from 6:00 - 6:55 a.m., the lock on the upper right door to the medication cupboard was noted to be broken. Inside the cupboard were the following drugs:</p> <ul style="list-style-type: none"> <li>- 3 bottles of Polyethylene Glycol (a laxative drug).</li> <li>- 1 bottle of Mucinex Cold For Kids (an expectorant drug)</li> <li>- 1 bottle of Tussin DM (an expectorant drug)</li> <li>- 1 box of Generic Sudafed (an adrenergic drug)</li> <li>- 1 box of Bisacodyl USP Suppositories (a</li> </ul>	W 382	<p><b>W 382 483.460(l)(2) DRUG STORAGE AND RECORD KEEPING</b></p> <p>The lock has been replaced. This will be added to the checklist already in place and checked daily by the administrator.</p> <p>To be completed by the Administrator by 11/25/08.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 382	<p>Continued From page 23 laxative drug).</p> <p>When asked during the environmental review, on 9/23/08 from 9:35 - 9:50 a.m., the RSC stated the lock had recently broken and was scheduled to be repaired. The RSC stated the drugs should have been moved to the lower locked cabinet when the lock broke.</p> <p>The facility failed to ensure all drugs remained locked.</p>	W 382			



C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

# IDAHO DEPARTMENT OF HEALTH & WELFARE

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

October 27, 2008

Teresa Carpenter, Administrator  
Preferred Community Homes Courtyard  
615 Second Avenue West  
Wendell, Idaho 83355

Re: Informal Dispute Resolution Conference  
Preferred Community Homes Courtyard

Dear Ms. Carpenter:

Attached are the findings of the Informal Dispute Resolution Panel's decision.

Enclosed you will find the amended survey report. Please resubmit the facility's Plan of Correction for the remaining deficiencies and return the 2567 to this office by **November 10, 2008**. This will become the facility's survey of record.

Should you have any questions or concerns please do not hesitate to contact me at (208) 334-6626. Thank you for your participation in this process.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T.  
Chief  
Bureau of Facility Standards

DR/lj

Enclosures

COPY

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments  This report incorporates changes resulting from the Informal Dispute Resolution (IDR) process. The surveyors conducting the survey were: Jim Troutfetter, QMRP, Team Leader Michael Case, LSW, QMRP	M 000	<b>M00 16.03.11 INITIAL COMMENTS</b>  "Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated September 25, 2008. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
MM163	16.03.11.075.03 Informed of One's Medical Condition  To Be Informed of One's Medical Condition. Each resident admitted to the facility must be fully informed of his medical condition, by a physician, unless medically contraindicated, as documented by a physician in his record, and must be afforded the opportunity to participate in the planning of his total care and medical treatment. This Rule is not met as evidenced by: Refer to W124.	MM163	MM163 16.03.11.075.03 INFORMED OF ONE MEDICAL CONDITION  REFER TO W124	
MM177	16.03.11.075.09 Protection from Abuse and Restraint  Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	MM177 16.03.11.075.09 PROTECTION FROM ABUSE AND RESTRAINT.  REFER TO W149	
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file	MM197	MM197 16.03.11.075.10(d) WRITTEN PLANS  REFER TO W289 AND W312.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

*Jeresa Carpenter*

TITLE *Admin*

(X6) DATE

*10/30/08*

6899

LKU311

If continuation sheet 1 of 5

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTY/</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM197	Continued From page 1  in the facility; and  This Rule is not met as evidenced by: Refer to W289 and W312.	MM197		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals  All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:  1. An environmental review was conducted on 9/23/08 from 9:35 - 9:50 a.m. At that time, the following toxic chemicals were noted to be unlocked:  Sitting on the floor of the laundry room: - Two 1-1/2 gallon bottles of bleach  In an unlocked cabinet in the laundry room: - Six cans of glass cleaner spray - One bottle of Soft Scrub cleanser with bleach - Three cans of Lysol disinfectant spray - Two bottles of Spray and Wash fabric treatment with Resolve - One bottle of Clorox Clean Up with bleach - One can of Pledge dusting spray  The RSC, who was present during the review, stated the items should have been locked. The RCS had staff lock the items.  The facility failed to ensure all toxic chemicals were stored in appropriate areas under lock and	MM271	<b>MM271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS</b>  All toxic chemicals will be locked. This will be added to a checklist and signed off daily by the RSC, and/ or Administrator. To be completed By 11/25/08.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTY/</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM271	Continued From page 2 key.	MM271			
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:</p> <p>An environmental survey was conducted in the facility on 9/23/08 from 9:35 - 9:50 a.m. and the following concerns were noted:</p> <p>a. There was a hole in the dry wall above the light switch in Individual #2's bathroom approximately 6 inches by 4 inches.</p> <p>b. There was 4 small nails protruding from the padding to the right of Individual #4's bed.</p> <p>c. The caulking around the toilet in the medication room was cracked and missing in places, and a dark liquid was present in some of the cracks.</p> <p>d. There was glass missing from the bottom door of the entertainment center in the living room.</p>	MM380	<p>MM380 16.03.11.120.03(a) Building and Equipment</p> <p>The hole in the dry wall in individual #2 bathroom will be replaced. The 4 small nails in individual #4 bed. The caulking in the med room will be replaced. The glass in the entertainment center will be replaced.</p> <p>To be completed by the RSC, Maintenance man, and the Administrator by 11/25/08.</p> <p>MM573 16.03.11.210.05(e) Health care complaints</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTY/</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM573	Continued From page 3	MM573	Refer to W315		
MM573	16.03.11.210.05(e) Health Care Complaints  Notation record of the individual resident's health care complaints and problems together with evaluation and action followed. This Rule is not met as evidenced by: Refer to W315.	MM573			
MM725	16.03.11.270.01(b) QMRP  The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM725 16.03.11.270.01(b) QMRP  Refer to W159.		
MM729	16.03.11.270.01(d) Treatment Plan Objectives  The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	MM729 16.03.11.270.01(d) Treatment Plan Objectives  Refer to W227.		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data  Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 16.03.11.270.01(d)(i) Diagnostic and Prognostic Data.  Refer to W214		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM735	Continued From page 4	MM735		
MM735	16.03.11.270.02 Health Services  The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	MM735 16.03.11.270.02 Health Care  Refer to W322.	
MM753	16.03.11.270.02(f)(i) Locked Area  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	MM753 16.03.11.270.02(f)(i) Locked Areas  Refer to W382	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation  Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859	MM859 16.03.11.270.08(f)(i) Supervision of training and Habilitation.  Refer to W210	